TO THE
NORTH CAROLINA GENERAL ASSEMBLY

BY THE
MEDICAID INVESTIGATIONS DIVISION
OF THE
NORTH CAROLINA DEPARTMENT OF JUSTICE

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I. INTRODUCTION

The Medicaid Fraud Control Unit, which in North Carolina is the Medicaid Investigations Division ("MID") of the North Carolina Attorney General's Office, is required to prepare and deliver this report pursuant to N.C.G.S. § 114-2.5A, reporting its activities to the General Assembly.

Because the MID receives 75% of its funds from a Federal source, the MID is required by its Federal funding source to maintain statistics and report its activities based on the Federal fiscal year, which is October 1 through September 30. The General Assembly requires that this report present statistics based on the state fiscal year of July 1 through June 30. Pursuant to G.S. § 1-617, the General Assembly also requires a report on qui tam cases for the calendar year of January 1 through December 31. While these three reports overlap, the statistics presented in these three reports will vary because they each cover different time periods.

G.S. § 114-2.5A requires the report on the MID's activities during the previous state fiscal year to include specific information as follows:

Information Required

(1) The number of matters reported to the MID.
(2) The number of cases investigated.
(3) The number of criminal convictions and civil settlements.
(4) The total amount of funds recovered in each case.
(5) The allocation of recovered funds in each case to
    (i) the federal government; (ii) the State Medical Assistance Program; (iii) the Civil Penalty and Forfeiture Fund; (iv) the N.C. Department of Justice; and (v) other victims.

II. OVERVIEW

The MID presents this report to the Chairs of the Appropriations Subcommittees on Justice and Public Safety and Health and Human Services of the North Carolina Senate and the North Carolina House of Representatives and to the Fiscal Research Division of the Legislative Services Office. The report covers the activities of the MID for the State Fiscal Year 2013-2014 ("FY 13/14"), covering July 1, 2013 through June 30, 2014.

The MID has worked hard to combat Medicaid provider fraud, the physical abuse of patients in Medicaid funded facilities, the misappropriation of patient funds, and fraud in the administration of the Medicaid program during our 33 year history. In that time over 540 providers have been convicted of crimes relating to Medicaid provider fraud, the physical abuse of patients in Medicaid funded facilities, the misappropriation of patient personal funds, and fraud in the administration of the Medicaid program, and the MID has recovered over $670 million in fines, restitution, interest, penalties, and costs.

However, the past fiscal year marked significant changes in the operation and reporting by the NC Division of Medical Assistance and its technological systems. Some of these changes, which will be described in more detail in Section VI, have had significant effect on how the MID accesses the expenditure of Medicaid funds and to whom, and have significantly decreased the abilities of the Medicaid Fraud Control Unit during the previous fiscal year. The problems have slowed work and have the potential to decrease fraud detection and collections in the next year.

The MID continues to maintain strong relationships with the North Carolina Department of Health and Human Services ("NC DHHS"), the state agency that administers the North Carolina Medicaid Program, and with other law enforcement and prosecutorial agencies. Throughout FY 13/14, the MID continued joint investigations of fraud and patient abuse cases with a number of law enforcement and investigatory agencies, including the United States Department of Health and Human Services Office of Inspector General ("OIG"), Office of Investigations District Office in Greensboro, N.C.; the Federal Bureau of Investigation ("FBI"); U.S. Secret Service; the Internal Revenue Service; the United States Department of Justice; N.C. State Bureau of Investigation; and local law enforcement agencies, along with integrity Special Investigations Units (SIUs) within private insurance companies. These relationships serve as a valuable resource for future case referrals.

In the spring of 1994, through the efforts of the MID and the FBI, a Federal-State Health Care/Insurance Fraud Information Sharing Task Force was organized and began its operation. Charlie Hobgood, Director of the MID, serves as co-chair of the Group. In addition to the MID and the FBI, agencies with representatives on the Task Force include the Office of Inspector General (OIG), Internal Revenue Service, Postal Inspectors, Defense Criminal Investigative Service, North Carolina Department of Insurance, and Drug Enforcement Administration, Office of Personnel Management, Criminal and Civil sections of the United States Attorney's Office for the Eastern, Middle, and Western Districts of North Carolina, the North Carolina Division of Medical Assistance Program Integrity Section (DMA/PI), and other governmental and private health care programs. The Task Force meets quarterly for discussions of ongoing matters, information sharing and training. The MID also participates in the North Carolina Medicare Medicaid (MediMedi) Project. Director Charlie Hobgood is a member of the North Carolina MediMedi Steering Committee.

As in past years, Medicaid Fraud Control Units from other states seek advice and guidance in the areas of administration, investigation, and prosecution from the MID. The MID strives to maintain and build on this reputation and to assist other units directly and through participation with the National Association of Medicaid Fraud Control Units ("NAMFCU"). During FY 13/14, MID Director Charlie Hobgood served as a member of the NAMFCU Executive Committee. Director Hobgood has chaired a number of NAMFCU working groups and was team leader on a national settlement. MID Criminal Chief Doug Thoren served as Co-Chair of the NAMFCU Training Committee. MID Civil Chief Eddie Kirby was a member of the NAMFCU Global Case Committee and Qui Tam Subcommittee. MID Assistant Attorney General Steve McCallister served as Co-Chair of the NAMFCU Subpoena Working Group. MID Assistant

Attorney General John Parris was a member of the NAMFCU Record Retention Working Group. The MID continues to be actively involved in national global cases being coordinated through NAMFCU with the United States Department of Justice and other federal and state agencies. Director Hobgood, Civil Chief Eddie Kirby, Financial Investigator Winston Harrison and Assistant Attorney Generals Steve McCallister, Stacy Race, Clark Walton and Mike Berger served on NAMFCU global intake groups and teams appointed by NAMFCU's Global Case Committee. Five MID attorneys and twelve MID Financial Investigators worked on national or multistate qui tam cases.

The MID has worked to foster joint federal and state investigations and prosecutions of providers. The United States Attorney's Offices for the Eastern, Middle, and Western Districts have appointed a number of MID attorneys as Special Assistant United States Attorneys ("SAUSA") to pursue criminal and civil Medicaid fraud matters. MID attorneys receive many benefits from this appointment. MID attorneys are collaborating with attorneys in the United States Attorney's Offices for the Western, Middle and Eastern Districts of North Carolina on substantial criminal and civil fraud cases against a variety of Medicaid providers that began as investigations conducted by the MID. We will continue to foster our relations with these offices in the future.

The MID has a strong relationship with the North Carolina Division of Health Service Regulation ("NC DHSR"), the primary agency designated to receive patient physical abuse complaints from or involving long-term care providers in North Carolina. We anticipate our relationship with this agency will continue, which will provide the MID with a valuable source of referrals.

The MID, working with other agencies, was instrumental in developing a course through the North Carolina Justice Academy entitled, "Investigating Crimes Against the Elderly and Disabled." The course provides 24 hours of instruction and has been attended by approximately 315 law enforcement officers. This course is now being offered nationally and has been attended by officers from South Carolina and Georgia. MID Criminal Chief Doug Thoren is responsible for six hours of instruction on the legal issues surrounding abuse investigations.

During FY 13/14 the MID continued to provide an extensive training program for its staff. This training included sending staff to the NAMFCU Introduction to Medicaid Fraud 101 Training Program; the NAMFCU Medicaid Fraud 102 Training Program; the NAMFCU Annual Training Program; and the NAMFCU Global Case Training Program; and various courses relevant to fraud and abuse investigations and the use of computer programs in investigations offered by the Justice Academy of the N. C. Department of Justice, State Personnel Development Center, Office of State Personnel, and United States Attorney's Office. The MID and Division of Medical Assistance scheduled a yearly joint training to inform all staff of various policies of both agencies to further our common mission.

The North Carolina General Assembly enacted the North Carolina False Claims Act, G.S. §§ 1-605 through 1-618, which established a state qui tam law that went into effect on January 1, 2010. Since going into effect, this law has improved the MID's ability to prosecute and investigate Medicaid provider fraud and abuse. Since the North Carolina False Claims Act became effective, the MID received information from and filings by whistleblowers alleging approximately 340 cases of Medicaid fraud and abuse.

The federal Deficit Reduction Act ("DRA") provides that if a state enacts a state false claims act that is certified by the Inspector General of the United States Department of Health and Human Services as being as effective as the Federal False Claims Act in facilitating qui tam actions by relators (whistleblowers), the state is allowed to retain an additional ten percent of the Federal share of recoveries. However, the Inspector General has determined that the North Carolina False Claims Act does not comply with DRA because it does not contain the latest revisions to the Federal False Claims Act. In order to comply with DRA, the N.C. False Claims Act should be amended.

The MID enjoys the full support of Attorney General Roy Cooper who has worked to enhance cooperation between government agencies in fighting health care fraud and abuse of the elderly.

In summary, the MID's activities over the past year in both the criminal and non-criminal areas have proven highly productive. Our successful investigation and prosecution of a variety of Medicaid providers during FY 13/14 have served to maintain and enhance our reputation as an effective and professional investigative MID that vigorously, but fairly, pursues and prosecutes fraud and abuse.

III. INFORMATION REQUIRED ON MID ACTIVIITES

1. The number of matters reported to the MID.

There were 423 referrals made to the MID during the State FY 13/14. The referrals came from varied sources. The most valuable referrals came from the Program Integrity Section of the Division of Medical Assistance of the North Carolina DHHS. Referrals also came from citizens, law enforcement, and other governmental agencies including the Division of Health Service Regulation and the State Auditor. Referrals also came from federal governmental agencies and contractors including the Department of Health and Human Services Office of Inspector General, Office of Investigations, the Federal Bureau of Investigation, the Internal Revenue Service, and U.S. Department of Justice, U.S. Attorney's Office. Referrals were also received from the NAMFCU and qui tam plaintiffs. Referrals also came from Managed Care Organizations (MCO) in connection with behavioral health services.

Of those 423 new referrals plus four (4) referrals that were pending at the beginning of the fiscal year, the MID opened new case files on 146 matters. The remaining 281 were referred to another agency for review, declined for insufficiency of the evidence, declined due

to the lack of reliable data that could be used in court, or rolled into existing MID investigations. In many instances it is appropriate to refer a matter to the North Carolina Division of Medical Assistance for further review or administrative action. DMA can compare the allegation to its history of the provider and conduct billing analysis and reviews to determine whether further investigation is appropriate. DMA may then refer the matter back to the MID with the additional data and analysis. In that case, the MID can reconsider whether to open an investigation. Alternatively, DMA may decide to apply one of the administrative remedies or sanctions it has at its disposal. It is also possible that the matter could be referred to another appropriate investigatory agency for action.

A number of referrals were declined on the grounds that the referral did not sufficiently allege Medicaid provider fraud. Some of the allegations were not substantiated by a preliminary review. In some instances the dollar amount of fraud alleged was low or the potential for successful criminal prosecution was low. Some of the allegations did not pertain to Medicaid provider fraud but rather pertained to Medicaid recipient fraud. The MID's federal grant does not allow the MID to use funding to investigate Medicaid recipient fraud. Therefore, the MID refers recipient fraud allegations to the Division of Medical Assistance and the county Department of Social Services. Please note that allegations of Medicaid recipient fraud should be referred to the Recipient Services Section of the Division of Medical Assistance, 919-855-4000, or the Fraud Section of the local county Department of Social Services.

Medicaid fraud investigations are complex and labor intensive. The consequences of a fraud conviction on a provider can be severe. Therefore, the MID takes great care to ensure that allegations are substantiated before proceeding with criminal charges or civil actions.

2. The number of cases investigated.

During FY 13/14 the MID staff investigated 561 cases. Due to the length of time required to properly investigate a case, a number of these cases were referred and/or opened prior to FY 13/14. The subjects of current investigations include community support providers; mental and behavioral health facilities; counselors and psychologists; physicians; dentists; psychiatrists; pharmacies; pharmaceutical manufacturers; durable medical equipment suppliers; transportation providers; home health care providers and aides; labs; radiological providers; nursing facilities; and hospitals. The MID is also investigating care givers accused of patient physical abuse at Medicaid funded facilities, and the theft of recipients' personal funds.

3. The number of Criminal Convictions and Civil Settlements.

a. Criminal Convictions

During FY 13/14, the MID successfully convicted 15 providers. These criminal convictions resulted in the recovery of $14,410,332.88 in restitution, fines, courts costs, supervision fees, and community services fees. Details of these convictions are set forth in Section IV of this report.

FY 13/14 was a year of significant accomplishments. One of the criminal cases concluded in 2013/2014 was the criminal convictions of Phyllis Harrell ("Harrell") and her son, Michael Trueblood ("Trueblood"). Harrell and Trueblood owned and operated Harrell Medical Transport, Inc., an ambulance and transportation service provider located in Gates County, North Carolina. In 2009, The MID began its joint investigation of Harrell and Trueblood with the Office of Inspector General ("OIG") based upon a fraud hotline tip.

MID joined with OIG, FBI, and The United States Attorney's Office for the Eastern District of North Carolina in this investigation. The investigation revealed that from 2004 to 2009 Harrell and Trueblood had submitted falsified billing claims to Medicare and Medicaid claiming to have performed "Advanced Life Support" ambulance transportation for recipients who were in fact transported to routine dialysis appointments by wheelchair vans. Harrell and Trueblood falsified "Ambulance Call Reports" ("ACR") in order to justify billing for Advance Life Support transportation. The falsified ACRs hide the fact that the recipients could walk or be transported by wheelchair van. The falsified ACRs also included the names of Harrell Medical Transport, Inc. staff members who did not provide the transports, and included fake vital signs and medical diagnosis. Staff members of Harrell Medical Transport stated that Harrell and Trueblood directed them to alter their ACRs by removing any information that indicated that the recipients were ambulatory, were transported in a wheelchair van, or could be transported by a wheelcar van instead of by an ambulance.

On November 19, 2012, Harrell and Trueblood were indicted in the Eastern District of North Carolina and arrested on charges of Conspiracy to Commit Health Care and Wire Fraud, Health Care Fraud, False Statements Relating to Health Care Matters, Conducting Transactions in Criminally Derived Property, and Making Material False Statements. On July 16, 2013, Harrell and Trueblood were indicted on more related charges by a superseding indictment, including Making False Statements to Influence a Bank on a Loan and Aggravated Identity Theft.

On November 15, 2013, pursuant to a plea agreement, Harrell and Trueblood pled guilty to one count of felony Conspiracy to Commit Health Care Fraud and Wire Fraud in District Court for the Eastern District of North Carolina in Raleigh, NC. On May 15, 2014, Federal District Court Judge Terrence W. Boyle sentenced Harrell to 72 months in federal prison, followed by 3 years of post-release supervision, and ordered Phyllis Harrell to pay a $100 assessment fee and $1,598,356.91 in restitution. On the same day, Trueblood was sentenced to 53 months imprisonment followed by 3 years of supervised release and ordered to pay restitution in the amount of $1,516,654.21.

MID reports all criminal convictions to the United States Department of Health and Human Services Exclusion Program which, in turn, will take administrative action to exclude these providers from future participation as providers in Medicaid and any other federally funded health care program for a period of years.

b. Civil Settlements

During this period the MID obtained 11 civil settlements and recovered $41,358,420.17 in damages, interest, civil penalties, and costs. Of significance was a civil settlement agreement with Janssen Pharmaceuticals, Inc. and Johnson & Johnson (collectively, J&J). This settlement resolved allegations made by four *qui tam* relators that J&J employed unlawful off-label marketing schemes to promote the company's sales of its atypical antipsychotic drug Risperdal. In particular, it was alleged that J&J engaged in illegal off-label marketing and kickback schemes to promote Risperdal for uses not approved by the federal Food and Drug Administration. The settlement also resolved the relators' allegations that J&J employed similar schemes to promote sales of another of its atypical antipsychotic drugs, Invega, during a more limited timeframe. North Carolina was one of a number of states that were prepared to intervene and litigate in two of the *qui tam* actions. Subsequently a settlement was negotiated by the U.S. Attorney's Office for the Eastern District of Pennsylvania, the U.S. Department of Justice, a settlement team appointed by the National Association of Medicaid Fraud Control Units, and the Office of Inspector General of the U.S. Department of Health and Human Services. Under the terms of North Carolina's settlement, the State of North Carolina recovered $39,082,422.31.

4. The total amount of funds recovered in each case.

Together, these 15 criminal convictions and 11 civil recoveries represent a total of $55,768,753.05 recovered for the State of North Carolina. Consistent with federal reporting instructions, recoveries are amounts individual and organizational defendants are ordered to pay in criminal cases and must pay in civil judgments and settlements and may not reflect actual collections. A case by case breakdown of the amounts recovered in each case and allocation of recovered funds is shown in Table A below.

5. The allocation of recovered funds in each case to (i) the federal government; (ii) the State Medical Assistance Program; (iii) the Civil Penalty and Forfeiture Fund; (iv) the of Justice; and (v) other victims.

The allocation of recovered funds in each case is case is shown in Table A as follows:

Table A Funds Recovered							
Name	Federal Government	NC Medicaid	Civil Penalty & Forfeiture Fund	NC DOJ Costs	Other	Total	
Victoria Michelle Finney Brewton Banks	4,590,827.94	2,479,598.58			574,292.80	7,644,719.32	*
Linda Radeker, LPC	3,990,346.08	2,166,328.60			300.00	6,156,974.68	*
Rodnisha Sade Cannon	1,651,722.07	889,584.29			400.00	2,541,706.36	
Harrell Medical Transport, Inc./Phyllis Harrell	1,416,752.52	38,542.27			143,162.12	1,598,456.91	*
Paul Lynn Trueblood	1,416,752.52	38,542.27			61,459.42	1,516,754.21	*
Charlotte Garnes-Carter	513,849.52	278,965.00			1,200.00	794,014.52	*
I Believe In Miracles/ Gloria Sawyer	314,657.97	169,133.50			394.50	484,185.97	
Michael McLean	257,483.66	142,397.78			300.00	400,181.44	*
Harvest House Community Development - Evelyn Fuller	257,483.66	142,397.78			300.00	400,181.44	*
Oriaku Hampton-Sowell	162,834.45	88,802.78			100.00	251,737.23	*
Gregory Lassiter	152,424.31	82,363.60			100.00	234,887.91	
Dr. Francis Bald	74,564.66	40,159.02			400.00	115,123.68	
Alternative Care Treatment Center/James Tillman	11,504.75	6,183.98			17,688.73	35,615.84	
Amadou Kebbeh	0.00	0.00			522.50	522.50	
Calvin A. Robinson	0.00	0.00			680.00	680.00	
Total Criminal Recoveries	8,857,989.68	4,812,164.17			740,179.03	14,410,332.88	*
Janssen (Resperdal)	24,541,805.09	6,074,119.02	5,839,127.07	481,527.34	2,145,843.79	39,082,422.31	
Wyeth Pharmaceuticals, Inc. & Pfizer (Rapamune)	853,811.38	208,994.57	205,016.36	16,906.80		1,284,729.11	
Kirk v. Carefusion Corporation, Healthpoint, Inc. & Cardinal Health, Inc. (Surgicept & Triseptin)	388,494.98	84,302.21	82,808.31	6,828.84	18,928.79	581,363.13	
Omnicare (Kurnik v. Omnicare)	69,702.19	31,830.89		1,305.55	6,752.57	109,591.20	
Joseph Fuentes & Christopher Russo v. Genzyme Corporation (Seprafilm)	67,280.96	12,666.34	12,272.77	1,012.08	8,519.21	101,751.36	
Kmart (Partial Refill)	63,474.98	25,039.14	9,205.34	1,408.18		99,127.64	
Giddarie v. Sanofi-Aventis(Hyalgan)	26,902.72	11,804.67		483.13	2,522.94	41,713.46	
Ista Pharmaceuticals (Xibrom)	16,289.95	2,321.91	3,703.35	246.48	1,320.31	23,882.00	
Dreams & Vision LLC	10,994.14	5,645.61		232.78		16,872.53	
Michael Yarberry v. Sears & Kmart	10,313.86	2,342.43	2,342.43	193.18		15,191.90	
Johnie K. Little	1,156.93	594.12		24.48		1,775.53	
Total Civil Recoveries	26,050,155.07	6,459,660.91	6,154,475.63	510,240.95	2,183,887.61	41,358,420.17	
Total Recoveries	34,908,144.75	11,271,825.08	6,154,475.63	510,240.95	2,925,066.64	55,768,753.05	*

* These defendants were ordered to repay $7,765,409.13 joint and severally. The Criminal Recoveries totals have been adjusted to reflect these joint and several judgments.

IV. CRIMINAL CONVICTIONS

U.S. v. VICTORIA FINNEY BREWTON

Victoria Brewton-Banks was the owner of multiple mental health provider agencies in Shelby, North Carolina. This matter was discovered during the course of another MID investigation.

The investigation revealed that Brewton-Banks had used Linda Radeker's provider number to bill for services not rendered. Brewton-Banks recruited multiple therapists to use their identities and provider numbers to bill for services which were not provided to Medicaid recipients. The conduct covered the period of 2008 through September 2012.

Brewton-Banks pled guilty to one (1) count of health care fraud conspiracy, six (6) counts of health care fraud, one (1) count of Aggravated Identity Theft, and one (1) count of filing a false income tax return. On April 9, 2014, the United States District Court sentenced Brewton-Banks to 111 months of active imprisonment. The court recommended participation in the federal inmate financial responsibility program as well as substance abuse treatment programs and educational and vocational opportunities. The Court also recommended that Brewton-Banks support dependents from her prison earnings and that she be placed as close to Shelby, North Carolina as possible. The Court further ordered 3 years supervised release on counts 1 through 7 and one year supervised release on counts 8 and 9. Brewton-Banks was ordered to pay a $900.00 assessment and $7,643,819.32 in restitution. (NC Medicaid: $7,070,426.52, of which she is jointly and severally liable with Linda Radeker for $5,597,236.25; IRS: $573,392.80). Finally, the Court ordered forfeited the defendant's interest in a vehicle seized pursuant to the criminal investigation.

U.S. v. LINDA SMOOT RADEKER

Linda Radeker, LPC, owned and operated a behavioral health company, Wellness Training Associates, in Shelby, NC. This case was referred to the MID by the Division of Medical Assistance.

The investigation revealed that, from 2008 to 2011, Radeker had essentially "rented out" her individual provider number to various businesses which purported to provide mental and behavioral health services in and around Shelby, NC. These businesses used Radeker's provider number to bill Medicaid for services as if Radeker was the attending clinician, when in fact no services were provided. In exchange for the use of her number, Radeker kept a percentage of the Medicaid reimbursements. Some of those reimbursements were used to purchase items such as vehicles or jewelry.

In September 2012, Radeker pled guilty in the United States District Court for the Western District of North Carolina to one (1) count of Health Care Fraud conspiracy and two (2) counts of money laundering. On August 8, 2013, the counts were consolidated for judgment

and the court sentenced Radeker to seventy-two (72) months in the Bureau of Prisons, and ordered her to pay $6,156,674.68 in restitution to the North Carolina Fund for Medical Assistance. Of that, Radeker is jointly and severally liable with Victoria Brewton for $5,597,236.25. Radeker was ordered to receive any substance abuse treatment, if eligible. Upon release, Radeker is to be placed on supervision for two (2) years for each count, to be served concurrently. Radeker is to report to probation within seventy-two (72) hours of her release, not commit any crime, follow standard conditions of probation in the Western District, and pay a special assessment of $300.00.

U.S. v. RODNISHA SADE CANNON

Rodnisha Sade Cannon was the owner of a mental health provider agency in Shelby, North Carolina. This matter was discovered during the course of another MID investigation.

The investigation revealed that Cannon had used the Medicaid provider number of a therapist named Arley Smith to bill for services not rendered. Cannon recruited multiple therapists to use their identities and provider numbers to bill for services which were not provided to Medicaid recipients. The conduct covered the period of September 2010 through September 2012.

Cannon pled guilty to one (1) count of attempted disposal and transfer of property to prevent seizure, one (1) count of conspiracy to commit health care fraud, one (1) count of aggravated identity theft, and one (1) count of conspiracy to commit money laundering. On April 8, 2014, the United States District Court sentenced Cannon to 102 months of active imprisonment. The court recommended participation in the federal inmate financial responsibility program as well as substance abuse treatment programs and educational and vocational opportunities. The Court also recommended that the Cannon support dependents from her prison earnings, that she participate in mental health treatment as recommended by a mental health professional, and that she be placed as close to Charlotte, North Carolina as possible. The Court further ordered three (3) years supervised release to run concurrently for the disposal and transfer of property to prevent seizure, conspiracy to commit health care fraud, and conspiracy to commit money laundering. The Court ordered one (1) year supervised release for aggravated identity theft. Cannon was ordered to pay $400.00 in assessment fees. Cannon was ordered to pay NC Medicaid $2,541,306.36 restitution. Finally, the Court ordered forfeited Cannon's interest in a vehicle seized pursuant to the criminal investigation.

U.S. v. PHYLLIS STALLINGS HARRELL

Phyllis Harrell owned and operated Harrell Medical Transport, Inc. (HMT), an ambulance service, in Belvidere, North Carolina. The case was predicated upon a referral received from the Office of Inspector General.

The MID worked jointly with the Office of Inspector General and the United States Attorney's Office for the Eastern District of North Carolina during this investigation. The

investigation revealed that HMT was providing ambulance services to Medicare and Medicaid recipients who were able to ambulate or walk. The conduct covered the period of January 1, 2004 through December 31, 2009.

On November 15, 2013, Harrell pled guilty to one (1) count of felony conspiracy to commit health care fraud and wire fraud in United States District Court for the Eastern District of North Carolina. On May 15, 2014, the District Court sentenced Harrell to 72 months in federal prison, followed by three (3) years of post-release supervision, and ordered Harrell to pay a $100 assessment fee and $1,598.356.91 in restitution. The Court ordered that restitution will be joint and several with the co-defendant, Paul Lynn Trueblood, for the amount of $1,516,654.21. Phyllis Harrell will be solely liable for the restitution to Vantage South Bank.

U.S. v. PAUL LYNN TRUEBLOOD

Paul Lynn Trueblood was the vice president for Harrell Medical Transport, Inc. (HMT), an ambulance service in Belvidere, North Carolina. The case was predicated upon a referral received from the Office of Inspector General.

The MID worked jointly with the Office of Inspector General and the United States Attorney's Office for the Eastern District of North Carolina during this investigation. The investigation revealed that HMT was providing ambulance services to Medicare and Medicaid recipients who were able to ambulate or walk. The conduct covered the period of January 1, 2004 through December 31, 2009.

On November 15, 2013, Trueblood pled guilty to one (1) count of felony conspiracy to commit health care fraud and wire fraud in United States District Court for the Eastern District of North Carolina. On May 15, 2014, the District Court sentenced Trueblood to 53 months in federal prison, followed by three (3) years of post-release supervision, and ordered Trueblood to pay a $100 assessment fee and $1,516,654.21 in restitution. The Court ordered that restitution be joint and several with the co-defendant, Phyllis Harrell.

U.S. v. CHARLOTTE ELIZABETH GARNES

Charlotte Garnes is a Licensed Professional Counselor (LPC) who was practicing in the Charlotte area. Garnes had her own Medicaid provider numbers which she used to submit billings for payment. Garnes also had a group Medicaid provider number for Charlotte's Insight, Inc. This case was initiated during the MID investigation of Teresa Marible-Wilson and A Time for Everything, a behavioral health provider owned by Joanna Patronis. The case was investigated jointly with HHS-OIG.

Teresa Marible-Wilson represented herself as a Provisionally Licensed Professional Counselor and began billing Medicaid for counseling services through Charlotte's Insight, the company owned by Garnes. Joanna Patronis, who owned a third party billing company, would then electronically submit the billings to Medicaid for payment, with both Garnes and Patronis

receiving a percentage of the paid claims. However, Marible-Wilson was not licensed to provide mental and behavioral health services.

Garnes claimed she was supervising Marible-Wilson; however, the North Carolina Board of Licensed Professional Counselors had no record of any supervisory agreement. Moreover, Garnes claimed she was reviewing Marible-Wilson's work, yet many of the claims submitted and paid were not substantiated by any notes. Garnes was also untruthful to investigators about others billing through Garnes' provider number and later recruited another co-conspirator into the scheme.

The conduct covered the period of March 2009 through April 2011. On February 8, 2013, Charlotte Garnes was found guilty after a jury trial of one (1) count of Health Care Fraud Conspiracy, one (1) count of Obstruction of Official Proceeding, and ten (10) counts of False Statements Relating to Health Care Matters. The United States District Court for the Western District of North Carolina sentenced Garnes on June 18, 2013, to a term of sixty (60) months incarceration. Upon release from prison, Garnes is ordered to serve a term of two (2) years on supervised probation, imposing the standard conditions of probation. Garnes was further ordered to pay a $1,200.00 assessment fee and a total of $792,814.52 joint and several with Teresa Marible-Wilson; $251,637.23 joint and several with Oriaku Sowell; and $20,383.31 joint and several with Michele Jackson.

STATE v. GLORIA SAWYER

Gloria Sawyer was the owner of I Believe in Miracles (IBIM), an HIV Case Management Provider located in Raleigh, North Carolina. This case was predicated upon a referral from the North Carolina Division of Medical Assistance (DMA).

The investigation revealed that Gloria Sawyer initially applied for a Medicaid provider number in November 2008 and disclosed to DMA that she had previously been convicted of a felony offense. That application was not approved. In July 2009, Sawyer applied again, but indicated on the second application that she had not been convicted of a felony. That application was approved, a Medicaid provider number was granted to Sawyer for IBIM, and she began applying for reimbursements from DMA for HIV Case Management services. The investigation also revealed that Sawyer had, in fact, been convicted of numerous felonies, some using aliases. Sawyer directed employees of IBIM to create false patient notes, backdate patient forms and to be untruthful to DMA auditors during an on-site audit. Many of IBIM's clients did not receive any of the services for which IBIM had billed. Sawyer was responsible for approving case management notes, billing services to Medicaid, and had access to the bank account to which Medicaid reimbursements were granted. The conduct covered the period of - November 2008 through October 2011.

Sawyer appeared in Wake County Superior Court and entered pleas of guilty to five (5) counts of Obtaining Property by False Pretenses. Sawyer was ordered to serve 16-20 months in

custody of the North Carolina Department of Corrections. Sawyer was also ordered to pay restitution to Medicaid in the amount of $483,791.47 and court costs in the amount of $394.50.

U.S. v. MICHAEL MCLEAN

Michael McLean worked as the manager for the Harvest House Community Development Corporation, a company offering community support services in Mebane, North Carolina. Harvest House was predominately under the control of Evelyn Fuller. This case was predicated upon a complaint made by a former Residential Counselor employed by Harvest House.

A joint MID and HHS-OIG investigation revealed a scheme by McLean and Fuller to defraud the Medicaid Program in connection with community support services by submitting claims to the program for services which were not actually rendered. Records from approximately June 1, 2007 through November 21, 2008 indicated that services had been provided to employees of Harvest House and other people in the community, when in fact no services had been provided. Witnesses confirmed that they had received payment for their Medicaid numbers during the time period that no services were provided for them or their children. Many of the witnesses indicated that they had initially expected that their children would receive community support services. Substantial cash withdrawals by Fuller and McLean were noted in the bank records of the various business accounts where Medicaid funds had been deposited. Records indicated that business accounts had been used to purchase luxury items such as furs and cars as well as travel unrelated to the business.

On February 27, 2013, McLean pled guilty in the United States District Court for the Middle District of North Carolina to one (1) count of conspiracy to commit health care fraud and two (2) counts of health care fraud. On August 27, 2013, the court sentenced McLean to thirty-six (36) months in the Bureau of Prisons, ordered him to pay restitution in the amount of $399,811.44, jointly and severally with Fuller, and ordered a special assessment of $100.00 on each of the three counts. Upon his release, he was ordered to serve three (3) years of post-release supervision and he was ordered not to work in the health care field in any occupation associated with claims, payments or billing involving the Medicaid Program.

U.S. v. EVELYN FULLER

Evelyn Fuller operated the Harvest House Community Development Corporation, a company offering community support services in Mebane, North Carolina. Fuller employed Michael McLean as manager of the company. This case was predicated upon a complaint made by a former Residential Counselor employed by Harvest House.

A joint MID and HHS-OIG investigation revealed scheme by McLean and Fuller to defraud the Medicaid Program in connection with community support services by submitting claims to the program for services which were not actually rendered. Records from approximately June 1, 2007 through November 21, 2008 indicated that services had been

provided to employees of Harvest House and other people in the community, when in fact no services had been provided. Witnesses confirmed that they had received payment for their Medicaid numbers during the time period that no services were provided for them or their children. Many of the witnesses indicated that they had initially expected that their children would receive community support services. Substantial cash withdrawals by Fuller and McLean were noted in the bank records of the various business accounts where Medicaid funds had been deposited. Records indicated that business accounts had been used to purchase luxury items such as furs and cars as well as travel unrelated to the business.

On February 27, 2013, Fuller pled guilty in the United States District Court for the Middle District of North Carolina to one (1) count of conspiracy to commit health care fraud and two (2) counts of health care fraud. On August 27, 2013, the court sentenced Fuller to twenty-six (26) months imprisonment. Fuller received a 30% reduction in her sentence, which would have been thirty-seven (37) months under the guidelines, for the substantial assistance she provided in facilitating the plea of McLean. Her sentence otherwise mirrors McLean's. Fuller was ordered to pay $399,811.44, jointly and severally with McLean, and ordered a special assessment of $100.00 on each of the three counts.

U.S. v. ORIAKU HAMPTON-SOWELL

Oriaku Hampton-Sowell was a Licensed Professional Counselor (LPC) who was practicing in the Charlotte area. Sowell had her own Medicaid provider number which she used to submit billings for payment. Sowell also had a group Medicaid provider number for Chancellor's Place, which she applied for prior to this investigation. This case was initiated during the MID investigation of Teresa Marible-Wilson and A Time for Everything, a behavioral health provider owned by Joanna Patronis. The case was investigated jointly with HHS-OIG.

Teresa Marible-Wilson represented herself as a Provisionally Licensed Professional Counselor and began billing Medicaid for counseling services through Charlotte's Insight, a company owned by co-conspirator Charlotte Garnes. Joanna Patronis, who owned a third party billing company, would then electronically submit the billings to Medicaid for payment, with both Garnes and Patronis receiving a percentage of the paid claims. However, Marible-Wilson was not licensed to provide mental and behavioral health services.

Garnes became concerned about the volume of claims submitted through Charlotte's Insight and contacted Sowell about submitting Marible-Wilson's claims. Sowell agreed to submit Marible-Wilson's claims under Sowell's provider number in exchange for a percentage of the Medicaid payments.

The conduct covered the period of October 2010 through April 2011. On July 9, 2012, Oriaku Sowell pled guilty to one (1) count of Health Care Fraud Conspiracy. The United States District Court for the Western District of North Carolina sentenced Sowell on June 18, 2013 to a term of twelve (12) months and one (1) day incarceration. Upon release from prison, Sowell is ordered to serve a term of two (2) years on supervised probation, imposing the standard

conditions of probation. Sowell was further ordered to pay a $100.00 assessment fee and a total of $251,637.23 in restitution to the Medicaid Program, which she is jointly and severally liable for the full amount along with co-conspirators Teresa Marible-Wilson and Charlotte Garnes.

U.S. v. GREGORY BENNY LASSITER JR.

Gregory Lassiter owned and operated Vision One Health Services, a behavioral health services company in Charlotte, North Carolina. This case was initiated during the MID investigation of Erica Holland and A Time for Everything, a behavioral health provider owned by Joanna Patronis. The case was investigated jointly with HHS-OIG.

Holland was submitting fraudulent Medicaid claims through Patronis' company, A Time for Everything, and thereafter splitting the proceeds of the Medicaid reimbursements. Patronis became concerned about the volume of claims submitted by Holland, and stopped billing for Holland. Holland approached Gregory Lassiter about submitting claims for Holland. Lassiter agreed to submit Holland's fraudulent Medicaid claims through Vision One Health Services in exchange for a percentage of the reimbursement.

Upon further investigation of Lassiter and Vision One Health Services, it was also discovered that many of the clinicians at Vision One did not have their own Medicaid provider numbers. As a result, Lassiter was submitting claims for services using the attending provider numbers of clinicians who did not perform the services and/or who did not work for Vision One.

The conduct covered the period of November 2009 through April 2011. On August 17, 2012, Gregory Lassiter pled guilty to one (1) count of Health Care Fraud Conspiracy. The United States District Court for the Western District of North Carolina sentenced Lassiter on July 11, 2013. The court sentenced Lassiter to a term of twenty-four (24) months' incarceration. Upon release from prison, Lassiter is ordered to serve a term of two (2) years on supervised probation, imposing the standard conditions of probation. Lassiter was further ordered to pay a $100.00 assessment fee and a total of $234,787.91 in restitution to the Medicaid Program, of which co-conspirator Erica Holland is jointly and severally liable for $93,000.00.

STATE v. DR. FRANCIS ARTHUR BALD

Dr. Francis Arthur Bald was a licensed oral surgeon and owner of Dr. Bald and Associates, located in Nags Head and Elizabeth City, North Carolina.

This case was predicated upon a hotline call from a former employee of Dr. Bald, alleging that Dr. Bald's dental and oral surgery business was fraudulently billing Medicaid for several services that were not being provided. The investigation substantiated the allegation. The conduct covered the period of January 1, 2010 through December 31, 2011.

On December 18, 2012, Dr. Bald was charged with one (1) count of felony defraud/obtain money/property from Medicaid and one (1) count of felony obtaining property by false pretenses. On September 5, 2013, Dr. Bald pled guilty to two (2) counts of misdemeanor attempted medical assistance provider fraud. The Wake County District Court sentenced Dr. Bald to 90 days in jail, suspended for 60 months of supervised probation, and ordered Dr. Bald to pay restitution of $114,723.68, a fine of $200.00, and court costs of $200.00.

STATE v. JAMES JUNIOR TILLMAN

James Junior Tillman worked as an associate professional or qualified professional for three companies who provided mental health services to Medicaid recipients in Fayetteville and LaGrange, North Carolina: Alternative Care Treatment Systems, Inc.; Evergreen Behavioral Management, Inc.; and Yelverton's Enrichment Services, Inc. This matter was referred to the MID by the Division of Medical Assistance.

The investigation revealed that during Tillman's employment from February 2010 through April 2012, he was not qualified for the associate professional position with Alternative or the qualified professional positions with Evergreen and Yelverton's. To appear qualified for employment in these positions, Tillman presented an altered diploma and transcript which he represented to these companies to be true. Each of these companies paid Tillman for his work as an associate or qualified professional, and in turn each company billed Medicaid for reimbursement.

On August 8, 2013, Tillman pled guilty to the misdemeanor offense of Attempted Medical Assistance Provider Fraud in Cumberland County Superior Court. Tillman was sentenced with imprisonment for forty-five (45) days with that sentence suspended for sixty (60) months on the conditions that the defendant be placed on supervised probation, pay $354.50 in court costs, pay restitution as detailed below, and not be employed in any position that receives funds from the N.C. Medicaid Program. The Court also ordered that once Tillman pays all monies owed to the court, his probation may be terminated.

Tillman was ordered to pay $35,615.84 of restitution with $25,000.00 to be paid on the date of plea. Yelverton's, which had already reimbursed the Division of Medical Assistance, was to receive $17,927.11 of the $35,615.84, and the North Carolina Fund for Medical Assistance was to receive $17,688.73. Tillman paid $25,000.00 to the Cumberland County Clerk of Court on August 8, 2013.

STATE v. AMADOU KEBBEH

Amadou Kebbeh was a health care tech working at Cherry Hospital located in Goldsboro, North Carolina. This matter was predicated upon a telephone call from Cherry Hospital Police Department.

The investigation revealed that Kebbeh assaulted a patient while working at Cherry Hospital on February 5, 2013. On October 16, 2013, a jury found Kebbeh guilty of one (1) count of misdemeanor assault on a handicapped person. The Wayne County Superior Court sentenced Kebbeh to 60 days in jail, suspended for six (6) months of unsupervised probation, and ordered Kebbeh to pay a fine of $100, plus court costs of $422.50. The court also ordered Kebbeh not to work at any Medicaid facility while on probation.

STATE v. CALVIN ROBINSON

Calvin A. Robinson was a health care tech working at Cherry Hospital located in Goldsboro, North Carolina. This case was predicated upon a referral received from Cherry Hospital Police Department. After a preliminary investigation by the Cherry Hospital Police Department, Robinson was charged with Assault on a Handicapped Person.

The MID investigation revealed that Robinson punched a patient in the face with a closed fist while working at Cherry Hospital on June 2, 2013. On August 14, 2013, Robinson pled guilty to one (1) count of misdemeanor Assault on a Handicapped Person. The Wayne County District Court sentenced Robinson to 60 days, suspended for 24 months of supervised probation, and ordered Robinson to pay a fine of $500.00 and court costs of $180.00. Robinson appealed to superior court for a jury trial at that time.

On February 17, 2014, Robinson remanded his case back to district court and accepted the sentenced ordered above, without a jury trial. The Superior Court granted Robinson's request for remand in open court. Robinson was processed for probation on the same day.

V. CIVIL RECOVERIES

JANSSEN PHARMACEUTICALS, INC.

Johnson & Johnson was a New Jersey corporation headquartered in New Brunswick, New Jersey. Janssen was a New Jersey corporation and a subsidiary of Johnson & Johsnon headquartered in Titusville, New Jersey and is the successor in interest to Ortho-McNeil-Janssen Pharmaceuticals, Inc., Janssen Pharmaceutical Products, L.P., and Ortho-McNeil Pharmaceutical Products, Inc. Janssen distributed, marketed and sold pharmaceutical products in the United States, including the drugs Risperdal and Invega. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that between January 1, 1999 through December 31, 2005, Janssen promoted the sale and use of Risperdal for conditions and patients for which it was not approved as and effective by the Food and Drug Administration ("FDA"). It was also alleged that from January 1, 2007 through December 31, 2009, Janssen promoted the sale and use of Invega for conditions for which it was not approved safe and effective by the FDA.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $39,082,422.31. Of that amount, the federal government received $24,541,805.09 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $14,540,617.22. Of this amount, $6,074,119.02 was paid to the North Carolina Medicaid Program as restitution and interest, $5,839,127.07 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $2,145,843.79 was paid to the qui tam plaintiff, and $481,527.34 was paid to the North Carolina Department of Justice for costs of collection and investigation.

WYETH PHARMACEUTICALS, INC.

Wyeth Pharmaceuticals, Inc. was a Delaware corporation headquartered in Collegeville, Pennsylvania. Pfizer, Inc. was a Delaware corporation headquartered in New York, New York. Wyeth. Wyeth distributed, marketed and sold pharmaceutical products in the United States, including an immunosuppressive drug sold under the trade name Rapamune. In October 2009, Pfizer acquired Wyeth and Wyeth became a wholly owned subsidiary of Pfizer. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that between September 1999 through December 2011, Wyeth knowingly promoted the sale and use of Rapamune for uses for which it had not been approved by the Food and Drug Administration, including for use in connection with solid organ transplant patients other than kidney transplant patients, which were not medically-accepted indications, and were not covered by Medicaid.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $1,284,729.11. Of that amount, the federal government received $853,811.38 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $430,917.73. Of this amount, $208,994.57 was paid to the North Carolina Medicaid Program as restitution and interest, $205,016.36 was paid to the Civil Penalty Forfeiture Fund for the support of public schools and $16,906.80 was paid to the North Carolina Department of Justice for costs of collection and investigation.

CAREFUSION CORPORATION

CareFusion was a Delaware corporation with its principal place of business in San Diego, California. CareFusion manufactured, marketed and sold a drug in the United States under the trade name ChloraPrep. This matter was referred to the MID by the *qui tam* plaintiff.

This settlement resolves allegations that between July 1, 2008 through August 31, 2011, CareFusion knowingly promoted the sale of ChloraPrep products for uses that were not approved by the Food and Drug Administration and knowingly made and/or disseminated unsubstantiated representations about the use of ChloraPrep products. It was also alleged that in 2008 CareFusions's predecessor corporation entered into agreements, as to which

CareFusion assumed legal and financial responsibility, for payments of monies to an entity known as Health Care Concepts, Inc. ("HCC") in order to conceal kickbacks to the physician owner of HCC for the purpose of promoting and inducing providers to use ChloraPrep, in violation of federal and state anti-kickback statutes.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $581,363.13. Of that amount, the federal government received $388,494.98 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $192,868.15. Of this amount, $84,302.21 was paid to the North Carolina Medicaid Program as restitution and interest, $82,808.31 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $18,928.79 was paid to the qui tam plaintiff, and $6,828.84 was paid to the North Carolina Department of Justice for costs of collection and investigation.

OMNICARE, INC.

Omnicare was a Delaware corporation with its principal place of business in Covington, Kentucky. Omincare specialized in providing pharmacy services to long term care facilities. This matter was referred to the MID by the *qui tam* plaintiff.

This settlement resolves allegations that between September 1, 2003 through June 30, 2005, Omnicare solicited and received remuneration from Amgen, Inc. in the form of discounts, market share rebates, grants, honoraria, speaker fees, consulting services, dinners, travel or fees for the purchase of data in exchange for influencing health care providers' selection and utilization of Aranesp within long term care settings and for implementing "Therapeutic Interchange" programs (also known as "switching" programs) intended to identify patients who were taking a competitor drug and to switch those patients to Aranesp.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $109,591.20. Of that amount, the federal government received $69,702.19 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $39,889.01. Of this amount, $31,830.89 was paid to the North Carolina Medicaid Program as restitution and interest, $6,752.57 was paid to the qui tam plaintiff, and $1,305.55 was paid to the North Carolina Department of Justice for costs of collection and investigation.

GENZYME CORPORATION

Genzyme was a biotechnology corporation based in Cambridge, Massachusetts. Genzyme distributed, marketed and/or sold a biomaterial-based medical device in the United States, under the trade name Seprafilm Adhesion Barrier. This matter was referred to the MID by the *qui tam* plaintiff.

This settlement resolves allegations that between January 1, 2003 through May 18, 2010, Genzyme engaged in illegal marketing practices to promote Seprafilm for off-label uses.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $101,751.36. Of that amount, the federal government received $67,280.96 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $34,470.40. Of this amount, $12,666.34 was paid to the North Carolina Medicaid Program as restitution and interest, $12,272.77 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $8,519.21 was paid to the qui tam plaintiff, and $1,012.08 was paid to the North Carolina Department of Justice for costs of collection and investigation.

KMART CORPORATION

Kmart was a Michigan corporation with its principal place of business in Hoffman Estates, Illinois. Kmart, within its retail stores operated a national pharmacy chain in forty-six (46) states and three (3) territories of the United States. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that between January 1, 2004 through October 17, 2005, Kmart billed the Medicaid program for certain full prescriptions when those prescriptions were only partially dispensed.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $99,127.64. Of that amount, the federal government received $63,474.98 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $35,652.66. Of this amount, $25,039.14 was paid to the North Carolina Medicaid Program as restitution and interest, $9,205.34 was paid to the Civil Penalty Forfeiture Fund for the support of public schools and $1,408.18 was paid to the North Carolina Department of Justice for costs of collection and investigation.

SANOFI-AVENTIS

Sanofi-Aventis distributed, marketed and/or sold pharmaceutical products in the United States, including an injectable viscosupplement device sold under the trade name Hyalgan. This matter was referred to the MID by the *qui tam* plaintiff.

This settlement resolves allegations that between 2005 through 2009, Sanofi-Aventis provided illegal remuneration to physicians to induce the physicians to purchase and to prescribe Hyalgan.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $41,713.46. Of that amount, the federal government received $26,902.71 to satisfy North

Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $14,810.75. Of this amount, $11,804.67 was paid to the North Carolina Medicaid Program as restitution and interest, $2,522.94 was paid to the qui tam plaintiff, and $483.13 was paid to the North Carolina Department of Justice for costs of collection and investigation.

ISTA PHARMACEUTICALS

ISTA Pharmaceuticals was a Delaware corporation with its principal place of business in Irvine, California. ISTA developed, distributed, marketed and sold pharmaceutical products in the United States, including the drug sold under the trade name Xibrom. This matter was referred to the MID by the *qui tam* plaintiff.

This settlement resolves allegations that between January 1, 2006 through March 31, 2011, ISTA knowingly promoted the sale and use of Xibrom for the following uses for which Xibrom had not been approved as safe and effective by the Food and Drug Administration: treatment of cysoid macular edema ("CME"), prevention of CME, treatment of pain and inflammation associated with non-cataract eye surgery, treatment of glaucoma, and treatment of inflammation (other than postoperative inflammation). It was also alleged that ISTA paid illegal remuneration to certain ophthalmologists and optometrists to induce them to prescribe Xibrom.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $23,882.00. Of that amount, the federal government received $16,289.95 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $7,592.05. Of this amount, $2,321.91 was paid to the North Carolina Medicaid Program as restitution and interest, $3,703.35 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $1,320.31 was paid to the qui tam plaintiff, and $246.48 was paid to the North Carolina Department of Justice for costs of collection and investigation.

DREAMS & VISIONS, LLC

Dreams & Visions was a North Carolina corporation headquartered in Charlotte, North Carolina. Dreams & Visions operated a Residential Treatment, Level III home. This matter was referred to the MID by the Division of Medical Assistance.

This settlement resolves allegations that between January 1, 2010 through January 31, 2013, Dreams & Vision knowingly allowed a Licensed Professional Counselor, Johnie K. Little, to bill for mental health services that Little provided to group home residents when Dreams & Vision was also receiving payment for the provision of mental health services to these residents as part of Dreams & Vision's per diem reimbursement from Medicaid.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $16,872.53. Of that amount, the federal government received $10,994.14 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $5,878.39. Of this amount, $5,645.61 was paid to the North Carolina Medicaid Program as restitution and interest and $232.78 was paid to the North Carolina Department of Justice for costs of collection and investigation.

KMART CORPORATION

Sears was a Delaware corporation with its principal place of business in Hoffman Estates, Illinois. Kmart was a Michigan corporation with its principal place of business in Hoffman Estates, Illinois. Sears wholly owns Kmart, which operated retail stores containing pharmacies throughout the United States and its territories. This matter was referred to the MID by the *qui tam* plaintiff.

This settlement resolves allegations that between January 1, 2006 through November 22, 2013, Kmart improperly offered, redeemed, and/or provided monetary inducements, in the form of coupons and gift cards, for new and transferred prescriptions.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $15,191.90. Of that amount, the federal government received $10,313.86 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $4,878.04. Of this amount, $2,342.43 was paid to the North Carolina Medicaid Program as restitution and interest, $2,342.43 was paid to the Civil Penalty Forfeiture Fund for the support of public schools and $193.18 was paid to the North Carolina Department of Justice for costs of collection and investigation.

JOHNIE K. LITTLE

Johnie K. Little was a Licensed Professional Counselor operating in Charlotte, North Carolina. This matter was referred to the MID by the Division of Medical Assistance.

This settlement resolves allegations that between January 1, 2010 through January 31, 2013, Little billed for mental health services that she provided to group home residents when another provider, Dreams & Vision, LLC, also was receiving payment for the provision of mental health services to these residents as part of Dreams and Vision's per diem reimbursement from Medicaid.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $1,775.53. Of that amount, the federal government received $1,156.93 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $618.60. Of this amount,

$594.12 was paid to the North Carolina Medicaid Program as restitution and interest and $24.48 was paid to the North Carolina Department of Justice for costs of collection and investigation.

VI. PROSPECTUS

Each year the MID has consistently endeavored to achieve a high standard of excellence in our efforts to effectively and efficiently combat fraud and abuse within the Medicaid Program. While we are concerned that technical and resource issues may impact recovery and conviction levels in the short-term, we continue to be optimistic about the overall progress of our efforts to combat fraud and abuse in the Medicaid Program.

Our optimism is based on several factors. First, we continue to have a reliable exchange with our Medicaid single-state agency, DMA, especially the DMA/Program Integrity Section, as well as other state and federal investigative and prosecutorial agencies. These relationships have played an important role in the MID's success to date and should significantly contribute to the MID's accomplishments in future fiscal years. We continue to be involved in numerous global/multi-state cases which have potential for successful conclusions in future fiscal years.

Further, each of the Managed Care Organizations (MCOs) managing North Carolina's Behavioral Health Managed Care 1915(b)(c) Waiver program have appointed a Compliance Officer and Committee whose duties include implementing an effective system for identifying and reporting fraud. DMA and MID have provided training to the MCOs on identifying and reporting fraud. DMA and MID have been meeting on a periodic basis with the MCO compliance staff. MCO compliance staff has shown serious interest in the training and meetings and an understanding of the importance of reporting fraud. MCO compliance staff members have become an important source of fraud referrals in connection with the Medicaid behavioral health program, and we are optimistic that this collaboration will increase.

We also anticipate that during the upcoming fiscal year the MID will be able to identify and utilize available training opportunities for all staff disciplines. These training opportunities will increase the knowledge, skills, and abilities of MID staff and enable the MID to continue to increase its proficiency in investigating and prosecuting fraud and abuse.

All MID staff members have their own personal computers that allow attorneys and investigators to obtain necessary information expeditiously and efficiently. MID also has a document imaging system that allows investigators to scan and search voluminous records rather than relying on hard copies.

The Affordable Care Act (ACA), Title 42 C.F.R. 455.23, requires DMA to suspend payments to any Medicaid provider where there is a credible allegation of fraud unless the MFCU requests that suspension not be imposed if suspension would compromise an investigation. The MID and DMA have created a process of referrals and requests not to suspend required by the regulation. As a result of this regulation, DMA has been able to

suspend Medicaid providers when appropriate in order to prevent further fraudulent expenditures of taxpayer money, and in appropriate cases MID has been able to request that suspension not be imposed if suspension might compromise or jeopardize an investigation. For a full description of the regulation please see 42 C.F.R. 455.23.

For these reasons we remain optimistic as to the long term success of the MID. We remain committed to fight fraud and abuse in the Medicaid Program as efficiently and effectively as possible and pledge our best efforts toward the accomplishment of that goal.

However, our optimism must be tempered by a number of challenges that MID is facing.

First, as previously noted, the 2013/2014 fiscal year saw substantial changes in MID's ability to access Medicaid data through DMA's technological systems. DMA and its contractors have traditionally provided MID with quick and easy access to Medicaid data through data repository and access systems including the HP DRIVE system and the Intelligent Technologies WebSPOTLIGHT system. Federal regulations require that DMA provide MID with access to Medicaid data. MID relied on these systems to efficiently and effectively prosecute fraud and recover monies.

On June 30, 2013, DMA ended its contract with its fiscal agent, Hewlett Packard, and on July 1, 2013 the new fiscal agent, Computer Science Corporation (CSC), took over Medicaid claims processing and payment functions and implemented a new Medicaid Management Information System (MMIS) called NC TRACKS. In addition, DHHS entered into a contract with Truven Health Analytics, Inc. to provide a data analysis and access system called Advantage Suites. The MID was informed that the new data access and repository contracts with the new contractors were expected to become functional in September and October 2013. That did not happen and as a result MID lost access to reliable current data admissible in court.

To continue casework, MID accessed pre-July 2013 Medicaid data from the old HP DRIVE system that remained functional through December 2013. MID was able to download data from the old DRIVE system and use it to investigate and prosecute Medicaid fraud that occurred prior to July 2013.

Unfortunately, MID access to the pre-July 2013 DRIVE data ended in December 2013. As a result, MID does not have access to reliable pre-July 2013 data or current data that can be used in court.

Coinciding with the emerging data issues, referrals from Program Integrity declined from 122 referrals to MID in FY 12/13 to 54 referrals in FY 13/14. MID relies heavily on Program Integrity in identifying and referring fraud, and is concerned that Program Integrity is also being negatively impacted by data access issues.

In January 2014, MID leadership requested from DHHS written affirmation that Medicaid data available to MID through NC TRACKS and Advantage Suites possessed a level of accuracy and reliability equal to that of previous data retrieval systems. In response, DHHS

requested meetings to discuss data issues, and by April, 2014 MID and DHHS staff and contractors met on a weekly basis. While we are encouraged by DHHS efforts to resolve contractor issues, the problem of access to reliable data must be resolved for MID to achieve financial recoveries and criminal convictions at levels achieved in previous fiscal years.

Second, at the beginning of this past year 11 of MID's Financial Investigator/Auditors and Financial Investigations Supervisors were paid less than the market rate established for their positions by the Office of State Human Resources (OSHR). In the case of our Financial Investigations Managers, two were making approximately 25% less than market rate. Over the years MID has spent a great deal of time, money, and effort training our investigative staff. However, the ability to increase their salaries was limited after implementation of State guidelines that restricted State employee salary increases to 10% without sufficient written justification and OSHR and OSBM approval. Under the guidelines we could offer market rate salaries to non-State employees but were restricted in our ability to offer market rate salaries to trained MID employees. In the last 14 months MID lost ten Financial Investigators/Auditors and Financial Investigations Managers. While some retired, seven left for jobs with private companies or other state agencies where they were able to receive higher salaries. Once we train our Financial Investigators they become more marketable to private industry, and it is increasingly difficult to retain them under present guidelines. In the last 14 months we lost approximately half of our non-sworn investigative staff. This loss has placed an undue burden on existing staff to keep up with current caseloads and made it difficult for MID to efficiently investigate Medicaid provider fraud and to recover monies.